

STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [REDACTED]

Claimant

Reg. No: 2008-24847

Issue No: 2021

Case No: [REDACTED]

Load No: [REDACTED]

Hearing Date:

May 12, 2010

St. Joseph County DHS

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, an in-person hearing was held on May 12, 2010. Claimant's [REDACTED] appeared and testified on claimant's behalf.

Claimant [REDACTED]

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application based upon the fact that they determined that claimant had excess assets for purposes of receipt of Medical Assistance Benefits?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

- (1) On April 30, 2007, claimant filed an application for Medical Assistance (MA) Program.

- (2) On May 22, 2007, the department caseworker sent claimant's representative and claimant verification checklists requesting asset and income information.
- (3) The claimant's attorney requested extensions until June 12, 2007, August 31, 2007, October 23, 2007, February 19, 2008, and April 1, 2008.
- (4) Claimant deceased on March 28, 2008.
- (5) On April 13, 2008, the department case worker sent claimant notice that the application for Medical Assistance was denied because of lack of information because claimant had failed to provide verification information for nearly a year.
- (6) Claimant testified on the record that she had paid off the Nursing Home bills.
- (7) The evidence on the record indicates that claimant did not provide information about one of her husband's life insurance policies.
- (8) Claimant's attorney passed away in [REDACTED]

CONCLUSIONS OF LAW

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

Cooperation, Verification, and Eligibility Determination

DEPARTMENT POLICY

All Programs

Clients have rights and responsibilities as specified in this item.

The local office must do **all** of the following:

- . Determine eligibility.
- . Calculate the level of benefits.
- . Protect client rights. PAM, Item 105, p. 1.

CLIENT OR AUTHORIZED REPRESENTATIVE RESPONSIBILITIES

Responsibility to Cooperate

All Programs

Clients must cooperate with the local office in determining initial and ongoing eligibility. This includes completion of the necessary forms. PAM, Item 105, p. 5.

Client Cooperation

The client is responsible for providing evidence needed to prove disability or blindness. However, you must assist the client when they need your help to obtain it. Such help includes the following:

- . Scheduling medical exam appointments
- . Paying for medical evidence and medical transportation
- . See PAM 815 and 825 for details. PEM, Item 260, p. 4.

A client who refuses or fails to submit to an exam necessary to determine disability or blindness **cannot** be determined disabled or blind and you may deny or close the case. PEM, Item 260, p. 4.

All Programs

Clients must completely and truthfully answer all questions on forms and in interviews. PAM, Item 105, p. 5.

The client might be unable to answer a question about himself or another person whose circumstances must be known. Allow the client at least 10 days (or other timeframe specified in policy) to obtain the needed information. PAM, Item 105, p. 5.

FAP Only

Do **not** deny eligibility due to failure to cooperate with a verification request by a person **outside** the group. In applying this

policy, a person is considered a group member if residing with the group and is disqualified. PAM, Item 105, p. 5.

Refusal to Cooperate Penalties

All Programs

Clients who are able but refuse to provide necessary information or take a required action are subject to penalties. PAM, Item 105, p. 5.

Responsibility to Report Changes

All Programs

This section applies to all groups **except** most FAP groups with earnings.

Clients must report changes in circumstances that potentially affect eligibility or benefit amount. Changes must be reported **within 10 days**:

- . after the client is aware of them, or
- . the start date of employment. PAM, Item 105, p. 7.

Income reporting requirements are limited to the following:

- . Earned income
 - .. Starting or stopping employment
 - .. Changing employers
 - .. Change in rate of pay
 - .. Change in work hours of more than 5 hours per week that is expected to continue for more than one month
- . Unearned income
 - .. Starting or stopping a source of unearned income
 - .. Change in gross monthly income of more than \$50 since the last reported change. PAM, Item 105, p. 7.

See PAM 220 for processing reported changes.

Other reporting requirements include, but are **not** limited to, changes in:

- . Persons in the home
- . Marital status
- . Address and shelter cost changes that result from the move
- . Vehicles
- . Assets
- . Child support expenses paid
- . Health or hospital coverage and premiums
- . Day care needs or providers. PAM, Item 105, pp. 7-8.

For TLFA only, the client must report to the specialist any month the work requirement is not fulfilled.

Explain reporting requirements to all clients at application, redetermination and when discussing changes in circumstances. PAM, 105, p. 8.

Verifications

All Programs

Clients must take actions within their ability to obtain verifications. DHS staff must assist when necessary. See PAM 130 and PEM 702. PAM, Item 105, p. 8.

VERIFICATION AND COLLATERAL CONTACTS

DEPARTMENT POLICY

All Programs

Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements.

Obtain verification when:

- . required by policy. PEM items specify which factors and under what circumstances verification is required.
- . required as a local office option. The requirement **must** be applied the same for every client. Local requirements may **not** be imposed for MA, TMA-Plus or AMP without prior approval from central office.
- . information regarding an eligibility factor is unclear, inconsistent, incomplete or contradictory. The questionable

information might be from the client or a third party. PAM, Item 130, p. 1.

Verification is usually required at application/redetermination **and** for a reported change affecting eligibility or benefit level. PAM, Item 130, p. 1.

Verification is **not** required:

- when the client is clearly ineligible, or
- for excluded income and assets **unless** needed to establish the exclusion. PAM, Item 130, p. 1.

Obtaining Verification

All Programs

Tell the client what verification is required, how to obtain it, and the due date (see “ **Timeliness Standards**” in this item). Use the DHS-3503, Verification Checklist, or for MA redeterminations, the DHS-1175, MA Determination Notice, to request verification. PAM, Item 130, p. 2.

The client must obtain required verification, but you must assist if they need and request help. PAM, Item 130, p. 2.

If neither the client nor you can obtain verification despite a reasonable effort, use the best available information. If **no** evidence is available, use your best judgment.

Exception: Alien information, blindness, disability, incapacity, incapability to declare one's residence and, for FIP only, pregnancy must be verified. Citizenship and identity must be verified for clients claiming U.S. citizenship for applicants and recipients of FIP, SDA and MA. PAM, Item 130, p. 3.

Timeliness Standards

All Programs (except TMAP)

Allow the client 10 calendar days (**or** other time limit specified in policy) to provide the verification you request. If the client cannot provide the verification despite a reasonable effort, extend the time limit at least once. PAM, Item 130, p. 4.

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Send a negative action notice when:

- . the client indicates refusal to provide a verification, **or**
- . the time period given has elapsed and the client has not made a reasonable effort to provide it. PAM, Item 130, p. 4.

MA Only

Send a negative action notice when:

- . the client indicates refusal to provide a verification, **or**
- . the time period given has elapsed. PAM, Item 130, p. 4.

Only **adequate** notice is required for an application denial. **Timely** notice is required to reduce or terminate benefits.

Exception: At redetermination, **FAP** clients have until the last day of the redetermination month **or** 10 days, whichever is later, to provide verification. See PAM 210. PAM, Item 130, p. 4.

TMAP

See PEM 647 regarding timeliness standards for TMA-Plus determinations. PAM, Item 130, p. 5.

In the instant case, claimant and his wife based upon the asset declaration had in excess of \$ [REDACTED] in assets as of August 20, 2006. Claimant failed to provide adequate verification of her assets for the date of application even though the department gave claimant's representative and claimant several extensions to provide verification information. BEM, Item 130, indicates that clients are allowed 10 calendar days to provide verification. If the client can not provide the verification despite a reasonable effort for Medical Assistance purposes, the department is to extend the time limit up to three times. In the instant case, the department extended the time limits 5 times and still the appropriate verification was not provided. Therefore, this Administrative Law Judge finds that the department was has established by the necessary competent, material and substantial evidence on the record that it appears that claimant in excess

of \$ [REDACTED] in countable available assets and that claimant failed to provide adequate verification of those assets.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that the department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it denied claimant's application for Medical Assistance benefits based upon its determination that claimant had in excess of \$ [REDACTED] in countable available assets at the time of application and based upon its determination that claimant failed to provide verification of those assets in a timely manner.

Accordingly, the department's decision is AFFIRMED.

/s/

Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: June 14, 2010

Date Mailed: June 16, 2010

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

2008-24847/LYL

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt date of the rehearing decision.

LYL/alc

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